Division of Health Care Finance & Administration

Health Care Innovation Initiative

Executive Summary

Gastrointestinal Hemorrhage (GIH) Episode

Corresponds to DBR and Configuration file V1.1

Updated: January 11, 2017

OVERVIEW OF A GASTROINTESTINAL HEMORRHAGE EPISODE

The gastrointestinal hemorrhage (GI hemorrhage) episode revolves around patients who are diagnosed with a GI hemorrhage. The trigger event is an inpatient admission, observation stay, or emergency department visit where the primary diagnosis is GI hemorrhage. In addition, a trigger event can be an inpatient admission, observation stay, or emergency department visit where the primary diagnosis is a symptom of GI hemorrhage and a secondary diagnosis is GI hemorrhage. All related care – such as anesthesia, imaging and testing, evaluation and management, and medications – is included in the episode. The quarterback, also called the principal accountable provider or PAP, is the facility where the GI hemorrhage was ultimately treated. The GI hemorrhage episode begins on the day of the triggering visit with a triggering diagnosis and ends 30 days after discharge.

CAPTURING SOURCES OF VALUE

Providers have multiple opportunities during a GI hemorrhage episode to improve the quality and cost of care. Example sources of value include the effective use of imaging and testing, and the appropriate use of blood transfusions. In addition, based on the patient diagnosis, providers can employ an evidence based choice of therapies and medications. Providers may be able to select an appropriate site of care and length of observation/stay, and can also reduce complications such as re-bleeding.

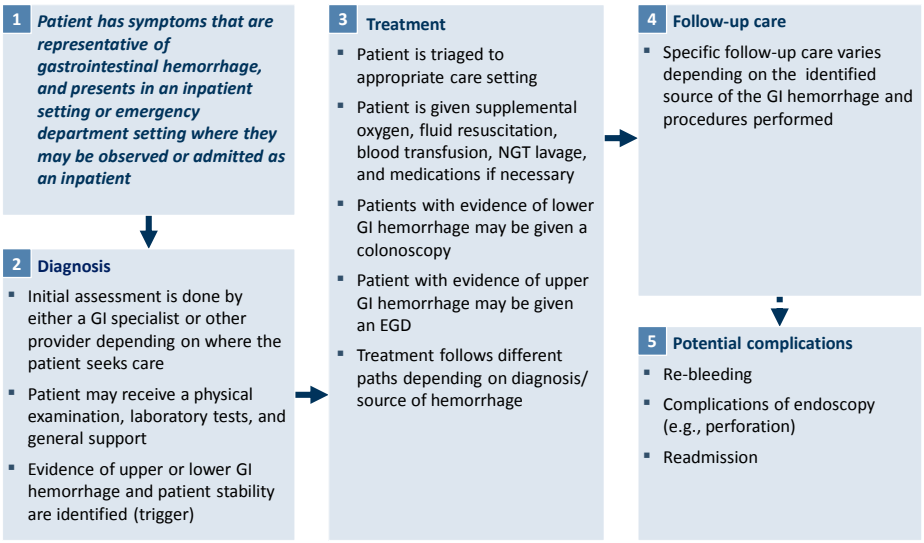
To learn more about the episode's design, please reference the following documents on our website at www.tn.gov/hcfa/topic/episodes-of-care:

- *Detailed Business Requirements: Complete technical description of the episode* http://www.tn.gov/assets/entities/hcfa/attachments/DBRGastrointestinalHemorrhage.pdf

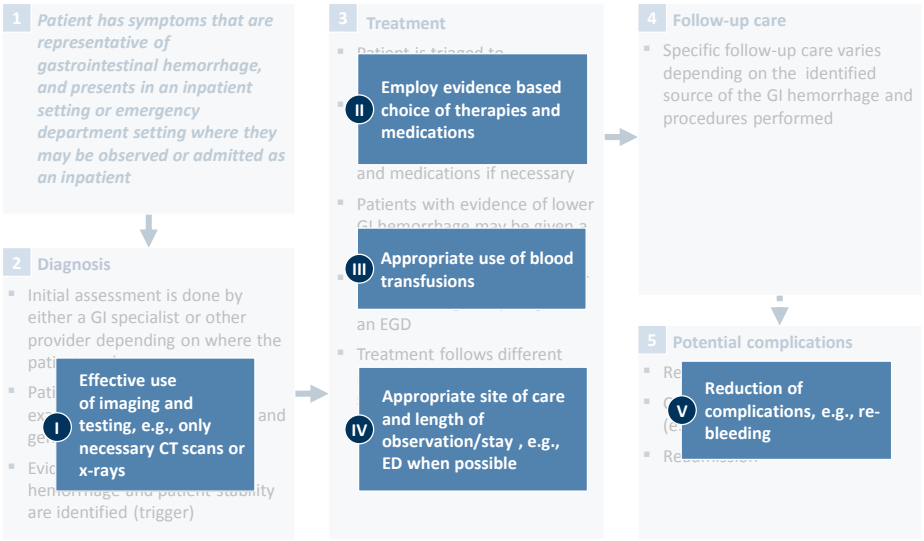
- *Configuration File: Complete list of codes used to implement the episode* http://www.tn.gov/assets/entities/hcfa/attachments/ConfigGIHemorrhagec.xlsx

Updated: August 26, 2016

Illustrative Patient Journey



Potential Sources of Value



Updated: August 26, 2016

ASSIGNING ACCOUNTABILITY

The quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the GI hemorrhage episode, the quarterback is the facility where the GI hemorrhage was ultimately treated. The contracting entity of the facility where the GI hemorrhage is ultimately treated will be used to identify the quarterback.

MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Inclusion of only the cost of services and medications that are related to the GI hemorrhage in calculation of episode spend.
- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The GI hemorrhage episode has no pre-trigger window. During the trigger window, all services and all medications are included. The post-trigger window includes care for specific complications, specific anesthesia, specific evaluation and management visits, specific imaging and testing, specific medications, specific pathology, and specific surgical and medical procedures.

Some exclusions apply to any type of episode, i.e., are not specific to a GI hemorrhage episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Other examples of exclusion criteria specific to the GI hemorrhage episode include a patient who has end stage renal disease (ESRD) or an organ transplant. These patients have

significantly different clinical courses that cannot be risk adjusted. Furthermore, there may be some factors with a low prevalence that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of GI hemorrhage episodes with factors likely to be impacted by risk adjustment include those patients with a history of esophageal disorders, gastroduodenal ulcers, or regional enteritis and ulcerative colitis. Over time, a payer may adjust risk factors based on new data.

MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metric linked to gain sharing for the GI hemorrhage episode is:

- **Follow-up care within the post-trigger window:** Percent of valid episodes where the patient receives relevant follow-up care within the post-trigger window (higher rate indicative of better performance).

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Follow-up care within the first seven days of post-trigger window:** Percent of valid episodes where the patient receives relevant follow-up care within the first seven days of the post-trigger window (higher rate indicative of better performance).
- **Emergency department visit within the post-trigger window:** Percent of valid episodes with a relevant ED visit within the post-trigger window (lower rate indicative of better performance).

- **Admission within the post-trigger window**: Percent of valid episodes with a relevant admission or relevant observation care within the post-trigger window (lower rate indicative of better performance).
- **Follow-up visit versus emergency department visit:** Percent of valid episodes with the first visit being a relevant follow-up visit within the post-trigger window, for valid episodes that had any post-trigger window visits (higher rate indicative of better performance).
- **Pseudomembranous colitis within the post-trigger window:** Percent of valid episodes with pseudomembranous colitis occurring within the post-trigger window (lower rate indicative of better performance).
- **Mortality:** Percent of total episodes with patient mortality within the episode window (lower rate indicative of better performance).

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.